



STATE HOSPITAL REFERRAL

State Form 52179 (R / 1-07) / CS 0020
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

Date of referral (month, day, year)

Update (month, day, year)

Mark all State Operated Facilities (SOFs) receiving

☐ EPCC

☐ ESH

☐ MSH

☐ LCH

☐ RSH

☐ LSH

Preference

☐ EPCC

☐ ESH

☐ MSH

☐ LCH

☐ RSH

☐ LSH

PATIENT INFORMATION

Name of patient (last, first, middle, maiden)		Date of birth (month, day, year)	Social security number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home address (number and street, city, state, and ZIP code)				County
Telephone number ()	Primary language	Previous SOFs		Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Commitment status <input type="checkbox"/> Temporary commitment <input type="checkbox"/> Regular commitment <input type="checkbox"/> ICST <input type="checkbox"/> Extended temporary <input type="checkbox"/> Commitment pending <input type="checkbox"/> Voluntary	Date of commitment (month, day, year)		County of commitment	
Any outstanding legal charges? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list county:	Explain:		
LOC for MR/DD <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of expiration (month, day, year)			
Check if <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Custodial Parent <input type="checkbox"/> Legal Guardian				
Name		Relationship		Telephone number ()
Home address (number and street, city, state, and ZIP code)				
Type of insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other		Insurance number(s)		
Financial resources and amounts <input type="checkbox"/> SSD \$ <input type="checkbox"/> SSI \$ <input type="checkbox"/> VA \$ <input type="checkbox"/> Other \$				Payee <input type="checkbox"/> Self <input type="checkbox"/> Other
Name of payee				
Address (number and street, city, state, and ZIP code)				

PSYCHIATRIC INFORMATION

Current placement		Date admitted (month, day, year)
Address (number and street, city, state, and ZIP code)		
Diagnosis - Axis I	Diagnosis - Axis II	Diagnosis - Axis III
GAF - past 12 months	GAF - current	IQ (MR/DD)
Current symptoms and behaviors - any changes:		
Brief history (presenting problems / risks including self harm, aggression, elopement, falls):		
Current medications and dosages		
Recent medication changes - why?		

TREATING PHYSICIAN	
Name of physician	Telephone number ()

MEDICAL NEEDS / SPECIAL NEEDS		
<input type="checkbox"/> Diet <input type="checkbox"/> Mobility <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Communication Difficulty <input type="checkbox"/> Allergies <input type="checkbox"/> Past History of T.B. PPD - Results _____	<input type="checkbox"/> Communicable Disease <input type="checkbox"/> Medical Equipment <input type="checkbox"/> Circulatory Issues (Heart Disease, HTN, etc.) <input type="checkbox"/> Respiratory (COPD, asthma) <input type="checkbox"/> GI Tract (ulcers, gastric reflux, colostomy G-tube, etc.)	<input type="checkbox"/> GU Tract - Urinary (dialysis, incontinence, catheter, etc.) <input type="checkbox"/> Diabetes <input type="checkbox"/> Neurological (seizures, NMS, altered gait) <input type="checkbox"/> Diabetic <input type="checkbox"/> Suicidal <input type="checkbox"/> Assaultive
Explain any items checked above and current treatment, if applicable. Copy of current physical may be used if current treatment is included. Attach additional sheets if necessary.		
Expectations of hospitalization and anticipated length of stay – specific and measurable goals for community reintegration:		

GATEKEEPER / DISCHARGE PLAN - COMMUNITY PLACEMENT NEEDS		
Assigned Gatekeeper		
Hospital Liaison		Telephone number ()
Address (number and street, city, state, and ZIP code)		
Signature		Date (month, day, year)
<input type="checkbox"/> SGL (24m) SMI/SA/SED <input type="checkbox"/> SGL (24m) MR/DD <input type="checkbox"/> Supported Living - MR/DD only <input type="checkbox"/> ICF/MR Facility - MR/DD only <input type="checkbox"/> Family Personal Home	<input type="checkbox"/> Specialized Residential Facility <input type="checkbox"/> Medical or Nursing Facility <input type="checkbox"/> Cluster Apt. Setting or SILP <input type="checkbox"/> DOC (forensic only) <input type="checkbox"/> Locked or Subacute	<input type="checkbox"/> RBA <input type="checkbox"/> Halfway Program - Chemical Addiction <input type="checkbox"/> AFA <input type="checkbox"/> Therapeutic Foster Care <input type="checkbox"/> Other: _____

GATEKEEPER / DISCHARGE PLAN - POST SOF PROGRAM NEEDS		
<input type="checkbox"/> Day Treatment / Partial Hospitalization <input type="checkbox"/> Intensive Outpatient <input type="checkbox"/> Medication Evaluation & Monitoring <input type="checkbox"/> Case Management <input type="checkbox"/> Substance Abuse Aftercare <input type="checkbox"/> Vocational & Employment Services	<input type="checkbox"/> ACT – Assertive Community Treatment <input type="checkbox"/> IDDT - Integrated Dual Diagnosis Treatment <input type="checkbox"/> SOC - Systems of Care (SED) <input type="checkbox"/> Children's Medicaid Waiver <input type="checkbox"/> Recreational Therapy - MR/DD only <input type="checkbox"/> Behavioral Modification & Support - MR/DD only	<input type="checkbox"/> Community Habilitation - MR/DD only <input type="checkbox"/> Health Care Coordination - MR/DD only <input type="checkbox"/> Prevocational / Sheltered Employment - MR/DD only <input type="checkbox"/> Other: _____ _____

STATE HOSPITAL REFERRAL DIRECTIONS

When admission to a state hospital is determined appropriate by the Gatekeeper, the State Hospital Referral Form is to be completed, signed by the Gatekeeper, and forwarded to the appropriate state hospital with the documents as listed below. Upon receipt of the form and required documents, the state hospital will contact the Gatekeeper within two working days regarding service / bed availability / waiting list.

The following documents are required with the Admission Referral Form:

- Current mental status (most recent psychiatric assessment) and significant findings
- Current risk factors (self-harm, aggression, elopement, falls, etc.)
- Most recent physical examination
- Any pertinent medical workups
- Commitment papers (or as soon as available; must be prior to admission)
- Legal papers (guardianship, wardship, legal charges, etc.)
- Current treatment plan (include current medications with dosages)
- Current psychological testing scores if available

Exceptions are:

- Result of TB test (date given and read). Test preferred within thirty (30) days, but required within ninety (90) days prior to admission

Additional documentation is required for MR/DD and Child/Youth Referrals with the Admission Referral form:

MR/DD Referrals

- Diagnostic and Evaluation
- DD Eligibility if Determined
- BDDS Involvement
- CMHC Screening
- School History and Education (IEP if available)
- Psychological testing scores and person/place to contact

Child/Youth Referrals - SED Waiver Enrollment

- Immunization
- School History & Education, Records & IEP (psychoeducational evaluation, if possible)
- History of Past Treatment
- Birth Certificate
- Institutional Level of Care

The Admission Referral Form must be submitted again at the time of admission to the state hospital. Only those sections noting changes since the referral (medication changes, legal changes, etc.) must be completed. This is to insure that the state hospitals have current information at admission. If the patient information remains the same as at the time of submission of the referral packet, you must submit the admission referral form again and indicate in the "Update" box, "No Changes." DMHA will be implementing a monitoring form to be used by admission staff at the state hospitals.